

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 0 0 1 1

2. STATE:

Arizona

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL  
SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

October 1, 2000

Oct 24

HHS HCFA  
DIVISION OF MEDICAID  
REGION IX

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

Section 1917 of the Social Security Act

7. FEDERAL BUDGET IMPACT:

a. FFY 1999/2000 \$ 0

b. FFY 2000/2001 \$ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Page 4 to the Addendum to Supplement 9  
to Attachment 2.6-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Page 4 to the Addendum to Supplement  
9 to Attachment 2.6-A

10. SUBJECT OF AMENDMENT:

Transfer of Assets

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

*Lynn Dunton*

13. TYPED NAME:

Lynn Dunton

14. TITLE:

Assistant Director

15. DATE SUBMITTED:

April 5, 2000

16. RETURN TO:

AHCCCS  
Mail Drop 4200  
Phoenix, Arizona 85034

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

10/24/00

18. DATE APPROVED:

*January 9, 2001*

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

10/01/00

20. SIGNATURE OF REGIONAL OFFICIAL:

*Linda Minamoto*

21. TYPED NAME:

Linda Minamoto

22. TITLE:

Associate Regional Administrator  
Division of Medicaid

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

TRANSFERS OF ASSETS (ON OR AFTER AUGUST 11, 1993)

Section 1917(c)  
of the Act

For transfers of assets on or after August 11, 1993, the State complies with 1917(c) of the Social Security Act, as amended by Section 13611 of the Omnibus Budget Reconciliation Act of 1993. Page 2 of Supplement 9 to Attachment 2.6-A specifies what constitutes undue hardship.

The period of ineligibility shall begin with the month in which such assets were transferred and the number of months in such period shall be equal to the total uncompensated value of the assets so transferred, divided by (check one of the following):

\_\_\_\_\_ \$\_\_\_\_\_, which is the average cost to, a private patient at the time of application, of nursing facility services in the State; or

  x   the average cost, to a private patient at the time of application, of nursing facility services in the community in which the individual is institutionalized. The average monthly costs for nursing facility services in the various communities in the State are listed below:

Developmentally Disabled

\$3,303.09 (entire State)

Non-developmentally Disabled

\$3,352.91 (Maricopa County)

\$3,352.91 (Pima County)

\$3,352.91 (Pinal County)

\$3,115.69 (balance of State)

TN No. 00-011

Supersedes

TN No. 00-005

Approval Date JAN 9 2001

Effective Date October 1, 2000